Ascension | MyHealth

URGENT CARE

ASCENSION MYHEALTH URGENT CARE, P.C.

Patient Registration Form

PATIENT NAME: LAST_____ FIRST_____ MI_____

DATE OF BIRTH: _____ / _____ / _____ SOCIAL SECURITY#: _____/_____/_____ SEX: ____M ____F

CURRENT ADDRESS:_____APT#_____

CITY: _____STATE: _____ ZIP CODE: _____

HOME PHONE :(_____)_____ CELL: (_____)_____OTHER:(_____)_____

EMAIL ADDRESS:_____

PREFERRED LANGUAGE: **HOW DID YOU HEAR ABOUT US:**

INSURANCE COVERAGE

PRIMARY POLICY:

POLICY HOLDERS NAME: _____RELATIONSHIP TO PATIENT: _____

POLICY HOLDERS D.O.B: _____/_____/____ INSURANCE COMPANY_____

SECONDARY POLICY:

POLICY HOLDERS NAME: _____RELATIONSHIP TO PATIENT _____

POLICY HOLDERS D.O.B: _____/_____/_____ INSURANCE COMPANY_____

General consent for testing and treatment

(Please read carefully before signing)

1.Consent to Testing and Treatment

I voluntarily consent to urgent care which may include a complete medical history, physical examination, routine diagnostic procedures, and such medical treatment as is deemed necessary and appropriate by the physician, physician assistant and/or associates at Ascension MyHealth Urgent Care, P.C.

I understand and agree that in the very rare event that a health care provider at Ascension MyHealth Urgent Care, P.C. sustains a significant exposure to my blood and/or bodily fluids that Ascension MyHealth Urgent Care, P.C., may have laboratory studies performed on my blood to detect the presence of a potentially serious incubating communicable disease, such as hepatitis or AIDS. The result of any such test will be treated confidentially.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee or promise has been made to me as to the results of the care and treatment which I have hereby authorized.

I authorize Ascension MyHealth Urgent Care, P.C. to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

2.Acknowledgment of Notice of Privacy Practices and Release of Medical Record Information

I acknowledge that I was offered and/or provided the MyHealth Urgent Care, P.C., Notice of Privacy Practices, and that I may obtain an additional copy of the Notice at any time. This Notice describes how Ascension MyHealth Urgent Care, P.C., uses and discloses medical information in accordance with the protections of the law.

I authorize Ascension MyHealth Urgent Care, P.C., to release pertinent information and/or copies of medical records of any information protected under the regulations in 42 Code of Federal Regulations, Part 2, if any,psychiatric/psychological/substance abuse/service records, if any, social work records, if any, including

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communications made to me by a social worker or psychiatrist/psychologist and any information about Human Immunodeficiency Syndrome (AIDS) to other institutions, physicians, third party payers, insurance companies or review agencies for use in connection with my care. I acknowledge that medical record information may be released to my employer if this is a work-related examination or injury for which a workers compensation claim has been filed.

3.Authorization for Payment

I assign and authorize payment directly to Ascension MyHealth Urgent Care, P.C., for any and all services rendered. I understand that I am financially responsible for services that may not be covered under my health insurance policy. I understand that it is my responsibility to pay, at the time of discharge, or on an interim basis as arranged with Ascension MyHealth Urgent Care, P.C., in accordance with its Payment for Services Policy (dated April 21, 2014) a copy of which I acknowledge that I have received, for all charges not covered by my insurance company, such as but not limited to deductibles and co-payments.

4.Additional Acknowledgements

I understand that Ascension MyHealth Urgent Care, P.C., and/or its business associates, may contact me by telephone at any telephone number provided by me or associated with my record, including cell phone numbers, which could result in telephone company charges to me. Ascension MyHealth Urgent Care, P.C., may also contact me by sending text messages or e-mail messages using the contact information I provide. Methods of contact may include using pre-recorded/synthetic voice messages and/or use of an automatic dialing device, if, when or as applicable.

I hereby release Ascension MyHealth Urgent Care, P.C., from responsibility for all personal articles which I have with me now and will have during my time as a patient at your urgent care facility. I understand that Ascension MyHealth Urgent Care, P.C., is not responsible for clothing, spectacles, dentures, money, personal electronic devices or other personal articles of value kept in my possession or anywhere on the premises during my time as a patient at your urgent care facility.

Authorizing Signatures

THE PURPOSE OF THIS FORM WAS EXPLAINED TO ME AND I HAD THE OPPORTUNITY TO ASK QUESTIONS.

Signature of Patient	**Date**	**Time**
Signature of Witness	**Date**	**Time**

If patient is unable to consent or is a minor, please complete the following:
Patient is a minor _____ years of age or patient is unable to consent because _____

Signature of Parent, Legal Guardian or Closest Relative	**Date**	**Time**
Signature of Witness	**Date**	**Time**